Par.1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 510-03 ACA Medical Eligibility Factors. This manual letter incorporates changes made with the following IM's if the information in the IM continues to be valid.

- IM 5456

Par. 2. **Effective Date** – Policy changes included in this manual letter are effective on or after **XXXX** unless otherwise indicated. Policy incorporated with the IM's is effective based on the date listed in the IM. Items that include a change in policy are indicated in **red**.

Definitions 510-03-05

1. 510-03-05 Definitions under ACA Medicaid incorporates the following changes in red from IM 5456.

Institutionalized Individual
An individual who is an inpatient in a nursing facility, an ICF/IID, the State Hospital, ~~Prairie at St. John's, the Stadter Psychiatric Center, an out-of-state~~ an intermediate care facility for mental disease (IMD), ~~the Anne Carlsen facility,~~ a Psychiatric Residential Treatment Facility (PRTF), or who receives swing bed care in a hospital.

Long Term Care, (LTC)
Refers to services received in a nursing facility, the State Hospital, ~~the Anne Carlson facility, Prairie at St. John's, the Stadter Psychiatric Center~~, an intermediate care facility for mental disease (IMD), a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for individuals with intellectual disabilities (ICF-IID), or a swing bed when the individual in the facility is screened or certified as requiring the services provided in the facility.

Nursing Care Services
Care provided in a medical institution, a nursing facility, a swing bed, the state hospital, ~~the Anne Carlson facility, Prairie at St. John's, the Stadter Psychiatric Center~~ an intermediate care facility for mental disease (IMD) , a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for individuals with intellectual disabilities (ICF-IID), or a home and community based services setting

Application and Decision 510-03-25

2. 510-03-25 Application and Decision under ACA Medicaid incorporates the

following changes in red from IM 5456

Application and Review 510-03-25-05

1. Application

c. An application is a request for assistance on a prescribed form designed and approved by the North Dakota Department of Human Services.

For ACA Medicaid Households, individuals can apply using one of the following prescribed applications:

i. The electronic file received by the state from the Federally Facilitated Marketplace (FFM) containing the single streamlined application;
ii. The single streamlined application as submitted through the North Dakota client portal;
iii. The SFN 1909, "Application for Health Coverage and Help Paying Costs";
iv. Telephonic applications utilizing any one of the prescribed applications;
v. SFN 405, "Application for Assistance"; or
vi. SFN 641, "Title IV-E/Title XIX Application-Foster Care";
vii. The Department's online "Application for Assistance", located at ~~http://www.nd.gov/dhs/.~~ http://applyforhelp.nd.gov
viii. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "HOSPITAL" stamped on the front page; or
ix. ICAMA (Interstate Compact on Adoption and Medical Assistance) form 6.01 "Notice of Medicaid Eligibility/Case Activation" stating North Dakota is responsible for the Medicaid coverage of the specified child.
x. SFN 958, "Health Care Application for the Elderly and Disabled". However, notification must be sent to the individual requesting information needed to make the ACA eligibility determination.
xi. An application submitted through the Self-Service Portal.

2. Review

b. A review must be completed at least annually using the Department's:

i. System generated "Monthly Report";
ii. System generated "Review of Eligibility;"
iii. SFN 407, "Review for Healthcare Coverage";
iv. SFN 642, "Title IV-E/Title XIX Redetermination-Foster Care" for children in Foster Care, or other confirmation from a state IV-E agency (in state or out of state) that verifies continued IV-E foster care eligibility;
v. One of the previously identified applications; or
~~vi. The on-line review through OASYS located at http://www.nd.gov/dhs/; o~~r
~~vii~~vi. The streamlined review received through the ND Client portal for ACA Medicaid reviews.
~~viii~~vii. When completing a review for children eligible for subsidized adoption assistance, receipt of one of the above reviews forms is not required. However, the following two criteria must be verified:
  - The child remains a resident of North Dakota; and
  - The child continues to be eligible for the subsidized adoption program.

  In addition contact should be made with the household to determine whether the child has obtained or lost other insurance coverage.

j. It is permissible to complete an early review of a child's eligibility for Medicaid and ~~Healthy Steps~~ Optional Children's Group. However, the household may not be required to provide any information that is needed specifically for determining only the eligibility of the Medicaid and ~~Healthy Steps~~ Optional Children's Group children who were determined to be continuously eligible. The family may voluntarily provide Medicaid and ~~Healthy Steps~~ Optional Children's Group specific information, but must not be required to do so.

Eligibility – Current and Retroactive 510-03-25-10

1. Current eligibility may be established from the first day of the month in which the signed application was received.

2. Retroactive eligibility may be established for as many as three calendar months prior to the month in which the signed application was received.

Eligibility can be established if all factors of eligibility are met during each month of retroactive benefits. If a previous application has been taken and denied in the same month, eligibility for that entire month may be established based on the current application. Retroactive eligibility may be established even if there is no eligibility in the month of application.

~~**Note:** This provision does not apply to individuals eligible only under the Adult Expansion Group for the months of October, November, or December 2013.~~

All case records shall be documented to reflect eligibility or ineligibility for each individual month assistance is requested prior to and through the month in which the application is processed.

3. An individual determined eligible for part of a month is eligible for the entire calendar month unless a specific factor prevents eligibility during part of that month. Examples of specific factors include:

   a. An individual is born in the month, in which case the date of birth is the first date of eligibility;

   b. An individual enters the state, in which case the earliest date of eligibility is the date the individual entered the state unless still receiving Medicaid benefits from another state. Information regarding the date Medicaid benefits from the other state are no longer available should be established in order to determine the beginning date of eligibility in North Dakota; or

   c. An individual is discharged from a public institution, in which case the earliest date of eligibility is the date of discharge.

4. A child cannot be eligible for Medicaid for the same period of time the child is covered under the Optional Children's Group.

5. For an ongoing Medicaid case, coverage may be added retroactively up to 12 months for a non-covered household member, provided the individual lived in the household during the months requested.

~~**Note:** Coverage under the Adult Expansion Group cannot begin prior to January 1, 2014.~~

Coverage Group 510-03-30

3. 510-03-30 Coverage Group under ACA Medicaid incorporates the following changes in red from IM 5456

Groups Covered Under ACA Medicaid 510-03-30-05

The following are the groups of individuals who can be covered under ACA Medicaid:

1. Categorically Needy Group

a. Parents and Caretaker/relatives of deprived children under age 18 (through the month they attain age 18) and their spouses up to 5446% FPL (COE of M063);

Assigning Category of Eligibility 510-03-30-15

3. Parents, Caretakers and their Spouses

COE	COE Description	Rule to Assign COE
63	Parents, Caretaker Relatives (& their Spouses) of Deprived Children	The Parent(s) or Caretaker: • Is the natural or adoptive parent, or a caretaker/relative within the 5th degree of relationship to a child under age 18 (through the month the child attains age 18); • Has a child residing with them who is deprived due to the absence, disability, incapacity, age or unemployment/ underemployment of a parent; • Has income below ~~5446~~% of the FPL.

ACA Eligible Individuals Health Care Coverage 510-03-30-20

1. Individuals who have their coverage under Traditional Medicaid are:

a. Eligible children under age 19.

b. Eligible parents and caretaker/relatives of deprived children under age 18 (through the month the child attains age 18) and their spouses with income below ~~54~~46% of the FPL.
c. Eligible parents and caretaker/relatives of deprived children under age 18 (through the month the child attains age 18), their spouses and children who are eligible as Transitional or Extended Medicaid.
d. Eligible pregnant women with income below 162% of the Federal Poverty Level (FPL) and for the duration of the 60 free day period.
e. Eligible foster care children.
f. Eligible Former Foster Care children.
g. Eligible individuals who have been approved for the Medicaid Breast or Cervical Cancer Early Detection Program and whose income is greater than 138% and less than 200% of the FPL.
h. Medically Needy eligible pregnant women, children under age 19 (through the month they attain age 19) and parents/caretaker relatives of deprived children under age 18 and their spouses.
i. Effective January 1, 2022, eligible individuals between the ages of 19 (the month following the month of their 19th birthday) and 20 (month prior to the month of their 21st birthday).

Basic Factors of Eligibility 510-03-35

4. 510-03-35 Basic Factory of Eligibility under ACA Medicaid incorporates the following changes in red from IM 5456

ACA Medicaid Household 510-03-35-05

2. Tax Dependent Unit

If a person is a **tax dependent**, that person's Medicaid household includes:

a. The individual,
b. The spouse who lives with them, (regardless if they file jointly or separately)
c. Everyone in the tax filers household, UNLESS the tax dependent meets one of the following **exceptions**:

i. The individual is claimed as a dependent by someone other than a parent, adoptive parent, or step-parent, (example by a grandparent or older adult sibling) or

ii. The individual is under age 19 and claimed as a dependent by an absent parent (example, child lives with Mom but absent Dad is claiming as a tax dependent), or

iii. The individual is under age 19 and lives with both parents but the parents do not expect to file jointly (example—parents live together but are not married).

d. If any of these individuals are pregnant, include the number of unborn children. ~~If more than one unborn child is expected, verification is required.~~

3. **Non-Filer Unit**

If a person is a **non-filer**, that person's Medicaid household is determined based on whether or not the non-filer is an Adult (Age 19 and older) or a Child (Under age 19).

- Non-filer Adult Household (age 19 or older) includes:

a. The non-filer adult, and
b. Their spouse who lives with them, and
c. Their natural, adopted or step-children under age 19
d. If any of these individuals are pregnant, include the number of unborn children. ~~If more than one unborn child is expected, verification is required.~~

- Non-filer Child Household (under age 19) includes:

a. The non-filer child,
b. The child's natural, adopted or stepparents who lives with them,
c. The child's natural, adopted or step siblings under age 19 who lives with them,
d. The child's spouse, who lives with them,
e. The child's natural, adopted or step children under age 19 who lives with them.
f. If any of these individuals are pregnant, include the number of unborn children. ~~If more than one unborn child is expected,~~

~~verification is required.~~

State Residence 510-03-35-85

1. For students entering the state to attend school full time and are between the ages of 18 and 22 (including the month the child attains age 22), who apply for ACA Medicaid on their own behalf, are considered North Dakota residents if the individual intends to remain in North Dakota when their education has been completed. Individuals who do not intend to remain in North Dakota when their education has been completed are considered to be residing in the state ~~temporary~~temporarily and are not considered a resident of North Dakota.

   Note: For students under age 18 policy outlined in #3 and #4 below applies.

Public Institutions 510-03-35-95

~~2. An individual under age 65 who is a "patient" in an IMD is not eligible for Medicaid, except as identified in subdivision d, unless the individual is under age 21 and is receiving inpatient psychiatric services and meets the certificate of need for admission. An individual who attains age 21 while receiving treatment, and who continues to receive treatment as an inpatient, may continue to be eligible through the month the individual attains the age of 22.~~

~~a. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases. A facility with 16 beds or less is not an IMD. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of mental diseases. An intermediate care facility for individuals with intellectual disabilities (ICF-IID) is not an IMD.~~

~~IMDs include the North Dakota State Hospital, facilities determined to be a Psychiatric Residential Treatment Facility (PRTF) by the Medical Services Division, Prairie at St. John's, and the Stadter Psychiatric Center. For any other facility, contact the~~

~~Medical Services Division for a determination of whether the facility is an IMD.~~

~~b. An individual on conditional release or convalescent leave from an IMD is not considered to be a "patient" in that institution. However, such an individual who is under age 21 and has been receiving inpatient psychiatric services is considered to be a "patient" in the institution until unconditionally released or, if earlier, the last day of the month in which the individual reaches age 22.~~

~~c. An individual on conditional release is an individual who is away from the institution, for trial placement in another setting or for other approved leave, but who is not discharged. An individual on "definite leave" from the state hospital is an individual on conditional release.~~

~~d. A child under the age of 19 who is determined to be continuously eligible for Medicaid, but who does not meet the certificate of need, remains eligible for Medicaid, however, no medical services will be covered during the stay in the IMD.~~

~~3.~~2. The period of ineligibility under this section begins the day after the day of entry and ends the day before the day of discharge of the individual from a public institution or IMD. A Ten-Day Advance Notice is not needed when terminating benefits due to entry into the public institution or IMD. See Paragraph (4)(c)(iii) of 510-03-25-25, "Decision and Notice," for further information

Institutions for Mental Disease (IMD) 510-03-35-97

An individual under age 65 who is a "patient" in an IMD is not eligible for Medicaid, except as identified in subdivision d, unless the individual is under age 21 and is receiving inpatient psychiatric services and meets the certificate of need for admission. An individual who attains age 21 while receiving treatment, and who continues to receive treatment as an inpatient, may continue to be eligible through the month the individual attains the age of 22.

a. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases. A facility with 16 beds or less is not an

IMD. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of mental diseases. An intermediate care facility for individuals with intellectual disabilities (ICF-IID) is not an IMD.

IMDs include the North Dakota State Hospital~~,~~ and facilities determined to be a Psychiatric Residential Treatment Facility (PRTF) by the Medical Services Division~~,. Prairie at St. John's, and the Stadter Psychiatric Center~~. For any other facility, contact the Medical Services Division for a determination of whether the facility is an IMD.

b. An individual on conditional release or convalescent leave from an IMD is not considered to be a "patient" in that institution. However, such an individual who is under age 21 and has been receiving inpatient psychiatric services is considered to be a "patient" in the institution until unconditionally released or, if earlier, the last day of the month in which the individual reaches age 22.

c. An individual on conditional release is an individual who is away from the institution, for trial placement in another setting or for other approved leave, but who is not discharged. An individual on "definite leave" from the state hospital is an individual on conditional release.

d. A child under the age of 19 who is determined to be continuously eligible for Medicaid, but who does not meet the certificate of need, remains eligible for Medicaid, however, no medical services will be covered during the stay in the IMD.

The period of ineligibility under this section begins the day after the day of entry and ends the day before the day of discharge of the individual from a public institution or IMD. A Ten-Day Advance Notice is not needed when terminating benefits due to entry into the public institution or IMD. See Paragraph (4)(c)(iii) of 510-03-25-25, "Decision and Notice," for further information.

Child Support Enforcement 510-03-40

5. 510-03-40 Child Support Enforcement under ACA Medicaid incorporates the following changes in red from IM 5456

Cooperation – Child Support 510-03-40-15

Cooperation with Child Support is required for all other legally responsible caretaker relatives for the purpose of establishing paternity and securing medical support, with the following exceptions:

1. Pregnant women are not required to cooperate with Child Support and may remain eligible for Medicaid while pregnant and through the month of the sixtieth post-partum day. A pregnant woman must be informed of this exception at the time of application or, in the case of a recipient, at the time the pregnancy becomes known. When Child Support is informed that an applicant or recipient is pregnant, Child Support services will continue to be provided; however, any non-cooperation by the pregnant woman will not affect her eligibility for Medicaid.

2. Recipients of Extended Medicaid Benefits and Transitional Medicaid Benefits are not required to cooperate with Child Support and remain eligible for Medicaid.

3. Caretaker relatives under age 19 who are within a continuous period are not required to cooperate with Child Support and remain eligible for Medicaid.

4. Parent/Caretaker relatives of subsidized adoption children are exempt from cooperation.

5. Parent/Caretaker relatives of deprived children are exempt from cooperation if they are not requesting Medicaid for themselves.

6. Caretaker relatives of deprived children where all the children in the household are eligible to receive services through Indian Health Services (IHS).

7. Caretaker relatives who have a pending or approved "good cause" claim.

The requirement may be waived for good cause as described in 510-03-40-20.

The determination of whether a legally responsible caretaker relative is cooperating is made by the Child Support Agency. The caretaker has the right to appeal that decision. Legally responsible caretaker relatives who are required to but do not cooperate with Child Support will not be eligible for Medicaid. Children in the Medicaid Household, however, remain eligible.

With the implementation of the Affordable Care Act, the request for information regarding an absent parent cannot be made prior to the Medicaid eligibility determination. Therefore, upon authorization of eligibility for a legally responsible caretaker relative who is required to cooperate with child support, a 'Request for Absent Parent Information' form will be sent to the caretaker. The caretaker will have 10 days to complete and return the form to the Eligibility Worker.

- If the caretaker does NOT return the completed form within 10 days, the Child Support Division automatically deems the caretaker to be non-cooperating and the caretaker's eligibility for Medicaid ended due to this non-cooperation. A 10-day Advance Notice is required.

- If the caretaker returns the completed form, the Eligibility Worker MUST enter the information provided by the caretaker immediately, but no later than 25 days from the date the form was mailed to the caretaker.

> **Note**: The form must be filed in the casefile and MUST NOT be mailed to the Regional Child Support Office.

Twenty-five (25) days from the date the form was mailed to the recipient, information for the case will be sent to the Child Support Agency. Until the electronic interface with CSEA is implemented, the CSEA will offer services to Medicaid families who are interested in receiving services and who are likely to cooperate.

~~**Note**: At the time the electronic interface with CSEA is implemented, updated information will be provided.~~

When a legally responsible caretaker relative is not eligible because of non-cooperation, the earned and unearned income of that ineligible caretaker must be considered in determining eligibility for the child(ren).

Should the caretaker return the form at a later date, the CSEA automatically deems the caretaker to be cooperating and the caretaker's eligibility can be restored effective the first day of the month in which the form was returned.

When a previously non-cooperating legally responsible caretaker relative reapplies for Medicaid after the Medicaid case closed, the caretaker relative is eligible for Medicaid until it is again determined that the caretaker relative is not cooperating.

Transitional and Extended Medicaid Benefits 510-03-50

6. 510-03-50 Transitinoal and Extended Medicaid Benefits under ACA Medicaid incorporates the following changes in red from IM 5456

Transitional Medicaid Benefits 510-03-50-05

A parent or caretaker relative who ceases to be eligible under the Parent/caretaker relative and their spouses category and who meets the requirements of this section may continue to be eligible for Medicaid benefits without making further application for Medicaid.

Note: Children eligible under one of the child categories, will remain eligible under that category when a parent or caretaker relative becomes Transitional Medicaid Eligible.

1. When at least one parent or caretaker relative, who was eligible under the Parent/caretaker (COE M063 ~~in Mini App~~) category in at least three of the six months immediately preceding the month in which the individual became ineligible because of the caretaker relative's hours or earnings from employment, may continue eligible for Medicaid benefits for up to twelve months if:

    a. The household has a child living in the home that meets the children's coverage age requirements; and

    b. The caretaker relative remains a resident of the state; and

c. The caretaker relative remains employed or shows good cause for not being employed (In families with two caretaker relatives, as long as one of the caretaker relatives remains employed; the provision is met. If both caretaker relatives stop working, the good cause provision applies to the last one that was employed); and

2. A family becomes ineligible under the Parent/caretaker (COE M063 ~~in Mini App~~) category because of the caretaker relative's earned income when it is determined that the household would continue to be eligible under the Parent/caretaker (COE M063 in Mini App) category, if the caretaker relative's earned income is not counted, but they fail when the earned income is counted.

3. An individual that seeks to demonstrate eligibility in at least three of the six months immediately preceding the month in which the household became ineligible must have been eligible in this state in the month immediately preceding the month in which the household became ineligible. Eligibility from another state may be substituted for the other two months. Verification of eligibility in another state is required.

4. Only recipients become eligible for Transitional Medicaid Benefits. Applicants who fail the Parent/caretaker (COE M063 in Mini App) category due to earned income must be eligible under the Parent/caretaker (COE M063 ~~in Mini App~~) category for at least one month, including any of the three prior months, before considering whether they were eligible under the Parent/caretaker category in three of the past six months.

5. If a child loses eligibility under one of the child categories during the parent/caretakers 12 month Transitional Medicaid Period, and the reason for the child's loss of eligibility is due to the parent/caretakers earned income, the child will be added to Transitional Medicaid for the remaining 12 month period of the parent/caretaker.

   Example 1: Household consists of mom and one child. Mom is eligible under the Parent/caretaker category in January and February.

- The entire case closes at the end of February per the family's request.
- In June, the family reapplies for Medicaid and requests assistance for the three prior months.
- When the application is processed, mom is NOT eligible under the Parent/caretaker category for March, but is in April.
- Mom fails under the Parent/caretaker category for May due to income.

Because mom received three months,(January, February and April), of coverage under the Parent/caretaker category in the past six months, mom became INELIGIBLE under the Parent/caretaker category due to earned income in May, and the mom was a recipient, Mom is eligible for Transitional Medicaid Benefits effective May 1.

- If mom's child is eligible under one of the child categories, the child remains eligible under that category and ONLY Mom becomes Transitional Medicaid Eligible.
- If mom's child is no longer eligible under one of the child categories, the child will also become Transitional Medicaid eligible at the same time as Mom does.
- If mom's child loses ~~eligible~~ eligibility under one of the child categories during mom's 12 month Transitional Medicaid Period, and the reason for the child's loss of eligibility is due to mom's earned income, the child will be added to Transitional Medicaid for the remaining 12 month period.

Example 2: Household consists of mom and 2 children. Mom is eligible under the Parent/caretaker category in January, February, and March.

- The case closes at the end of March per the family's request.
- In June, the household reapplies for Medicaid and does NOT request, or is not eligible for, assistance for April and May.

- When the application is processed, mom is NOT eligible under the Parent/caretaker category for June due to earned income.

Even though mom received three months, (January, February and March) of coverage under the Parent/caretaker category in the past six months, she is an applicant and not a recipient (no approved months based on this application). This household is NOT eligible for Transitional Medicaid Benefits.

6. If an individual was included as eligible under the Parent/caretaker category the month eligibility ended under the Parent/caretaker category, the individual is included in the Transitional Medicaid Benefits.

The following individuals are also eligible for Transitional Medicaid Benefits:

a. Children, deprived or non-deprived

   i. Who meet the age requirements under the Children category, and

   ii. Who are born, adopted, or who enter the home of a caretaker relative during the twelve month period, and

   iii. Who are not eligible under one of the children categories.

b. Parents who were absent from the household when the family became ineligible under the Parent/caretaker relative and their spouses category but who return during either period.

   Example: Mom and her child are eligible under the Parent/caretaker relative and their spouses category from January through April. Dad moves in during the month of April, and is not eligible under the Parent/caretaker relative and their spouses category. His earnings make mom and Dad ineligible under the Parent/caretaker relative and their spouses category for May, so mom is eligible for Transitional Medicaid Benefits beginning May.

Note: Dad is NOT eligible for Transitional Medicaid Benefits because he was not covered under the Parent Caretaker relative and their spouses category in the month coverage under the Parent Caretaker relative and their spouses category ended.

7. Children who no longer meet the age requirements are not eligible for Transitional Medicaid Benefits.

8. If a Transitional Medicaid Benefits case closes for loss of state residency and the household returns to the state and reapplies while still in the twelve-month period, eligibility may be re-established for the remainder of the Transitional period.

Refer to Section 510-03-85-40 for the Transitional Medicaid Benefits income level.

Extended Medicaid Benefits 510-03-50-10

A Parent(s) or caretaker relative who ceases to be eligible under the Parent/caretaker for Family Coverage category and who meets the requirements of this section, may continue to be eligible for Medicaid benefits without making further application for Medicaid.

Note: Children eligible under one of the child categories, will remain eligible under that category when a parent or caretaker relative becomes Extended Medicaid Eligible.

1. When at least one parent or caretaker relative, who was eligible under the Parent/caretaker or Family Coverage ~~(in Vision)~~ categories in at least three of the six months immediately preceding the month in which the parent/ caretaker relative became ineligible as a result (wholly or partly) of the collection or increased collection of spousal support (alimony) continue eligible for Medicaid for four calendar months if:

    a. The household has a child living in the home that meets the children's coverage age requirements; and

    b. The caretaker relative remains a resident of the state.

Hospital Presumptive Eligibility (HPE) 510-03-60

7. 510-03-60 Hospital Presumptive Eligibility under ACA Medicaid incorporates the following changes in red from IM 5456

Hospital Responsibility under Hospital Presumptive Eligibility (HPE) 510-03-60-50

1. Ensure the individual responsible for managing the Hospital's HPE and their designee's (person's assisting and completing HPE applications) attend all HPE Policy training provided by the Medicaid Eligibility Policy Unit of the North Dakota Department of Human Services and keep current with changes affecti~~ve~~ing HPE through various means of communication, including but not limited to the following:

    a. Participate in all in-person, telephone conference, webinar or computer-based HPE training sessions;
    b. Read all information provided regarding updates and changes to HPE.

Income 510-03-85

8. 510-03-85 Income under ACA Medicaid incorporates the following changes in red from IM 5456

Income Compatibility 510-03-85-25

Background

Provisions in the Patient Protection and Affordable Care Act of 2010 (PPACA or ACA) require states to rely as much as possible on electronic data sources when verifying information provided by applicants or recipients. Federal regulations restrict states from requesting verification from applicants or recipients unless the verification cannot be obtained through an electronic data source, or information from the data source is not "reasonably compatible" with what the applicant or recipient has reported.

Available Electronic Verification Sources

The Centers for Medicare and Medicaid (CMS) have defined electronic verifications received from the following sources to be valid when determining

reasonable compatibility for health care:

- ND Child Support (FACSES)
- ND State Directory of New Hires
- ND Job Service Unemployment Insurance Benefits
- ND Job Service Wage information, including the Quarterly Wage Verification
- Other Benefit Information (SSA and SSI Income)
- PARIS Interface

In addition to the above electronic verification sources, North Dakota ~~also~~ connects to the Federal Data Services Hub (FDSH) (TALX) which is free of charge to states and also directly with Equifax ~~effective February 8, 2016 North Dakota will connect to the Federal Data Services Hub (FDSH) in order~~ to obtain real-time verification of earnings ~~based on data from Equifax~~

- FDSH/TALX will be used for Medicaid Only cases.
- Equifax will be used for combination cases. A combination case is HCC and at least one other program (SNAP, CCAP, TANF, LIHEAP).
- ~~This verification service is available to states free of charge through the FDSH and can ONLY be used to determine eligibility for Health Care Coverage Programs.~~

Note: Employers are not required to provide their payroll information to FDSH/Equifax and therefore, verification of wages may not always be available through ~~TALX~~ these interfaces.

~~**Note**: Information received through the Federal Data Services Hub (FDSH) can ONLY be used to determine eligibility for Medicaid.~~

Budgeting 510-03-90

9. 510-03-90 Budgeting under ACA Medicaid incorporates the following changes in red from IM 5456

Budgeting Procedures for Medically Needy under ACA Medicaid 510-03-90-50

Parents and caretaker relatives of deprived children and their spouses, Pregnant Women and children under age 21, who fail under the ACA Medicaid

Categorically Needy Coverage Group, may be eligible under the ACA Medicaid Medically Needy Coverage Group, provided they have a Medical Need as defined in 510-03-35-35, Need.

To determine ACA Medicaid Medically Needy eligibility:

1. Determine if the individual has a Medical Need.

    a. Determine the ACA countable monthly income for the individual's household.

    b. Calculate and subtract 5% of the ACA countable monthly income to arrive at the net ACA countable monthly income.

    c. Subtract the appropriate ACA Medically Needy Income Level for the individuals' household size from the net ACA countable monthly income.

If the individual's household has a Medical need, eligibility can be determined for ACA Medicaid Medically Needy coverage.

~~**Note:** Processing for ACA Medicaid Medically Needy coverage is completed in the Vision System.~~

~~2. Once 'need' has been established, enter the case into Vision. Refer to the ACA Processing Guide, 'Determining ACA Medically Needy' section for instructions on processing ACA Medically Needy in Vision.~~

~~For new applications, **PRIOR TO** processing eligibility for Medically Needy under ACA Medicaid, please contact your Regional Representative.~~

~~For ongoing cases, each time a month is authorized, Medicaid Policy MUST be notified to ensure the correct COE is reported.~~

Budgeting Procedures for Three Months Prior (THMP) 510-03-90-60

When establishing eligibility for the three calendar months prior to the month in which the signed application was received, all factors of eligibility must be met during each month of retroactive benefits.

Retroactive eligibility may be established even if there is no eligibility in the month of application.

Budgets must be calculated for each of the three prior months, based on actual, verified income.

~~**Exception:** If the only eligible household members are children who were determined continuously eligible in one of the THMP months, budgets do not need to be calculated for any of the THMP months following the month the child became continuously eligible.~~

All case records shall be documented to reflect eligibility or ineligibility for each individual month assistance is requested prior to and through the month in which the application is processed.

Action on Reported Changes 510-03-90-65

Recipients are required to report changes in income, household size, employment, residence, new tax filing status, etc., within 10 days of their knowledge of the change. Because every household's circumstances are unique, all changes must be reported and reviewed, and it will depend on those circumstances whether it affects the recipient's coverage.

Under ACA Medicaid, clients will no longer be required to monthly report, but are required to report changes that may affect their eligibility, such as those itemized above. A revised change report has been created, which is currently being generated electronically. This is for the client's reporting convenience and does not require the individual to submit a form monthly.

We must not impose a threshold on what the household reports, or how often. In some cases, a $20 increase in income can make someone ineligible, in others; it may be a few thousand dollars. It all depends on the situation.

Therefore, there is no dollar amount or percentage threshold, all changes must be reported.

Upon receipt of a reported change, the Eligibility Workers will determine whether a change in eligibility results and process the change based on the policy defined in section 510-03-10-25, ~~Improper Payments and~~ Suspected Fraud.

> **Note**: The 10-10-10 requirements defined in section 510-03-90-10 and the Notification requirements defined in section 510-03-25-25 must be adhered to when acting on reported changes.

Related Programs 510-03-95

10. 510-03-95 Related Programs under ACA Medicaid incorporates the following changes in red from IM 5456

~~Children's~~ Special Health Services 510-03-05-40

~~Children's~~ Special Health Services provides services for children with special health care needs and their families. Services include coverage for diagnosis and treatment for children who have disabilities or chronic conditions. The program supports family-centered, community-based, coordinated services and systems of health care that meet the diverse needs of families. For information, contact the ~~Children's~~ Special Health Services ~~Program~~, North Dakota Department of Health, Division of ~~Maternal and Child Health~~Special Health Services (SHS), 600 East Boulevard Ave, Dept 301, Bismarck ND 58505-0200, or call 701-328-2436, 1-800-755-2714, or FAX: 701-328-1645.